U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 February 2005

In the Matter of:
HOWARD D. HOLT
Claimant

Case No.: 2003 BLA 5337

v.

EASTERN ASSOCIATED COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:
Mr. Howard D. Holt
Pro Se

Mr. Paul E. Frampton, Attorney
For the Employer

Ms. Francine A. Serafin, Attorney
For the Director

Before:
Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Howard D. Holt for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural History

First Claim

Mr. Holt filed his first application for black lung disability benefits on May 6, 1991. On October 23, 1991, the District Director denied the claim because Mr. Holt failed to establish the presence of pneumoconiosis and total disability. Mr. Holt did not appeal the decision (DX 1).[1]

Second Claim

Mr. Holt filed his second application for black lung disability benefits on August 2, 1993. On January 25, 1994, after reviewing the evidence, the claims examiner denied the claim for failure to prove total disability. Through a lay representative, Mr. Holt appealed the decision. Following a conference, the District Director denied the claim again on August 30, 1994 because Mr. Holt did not prove that he was totally disabled. On September 26, 1994 Mr. Holt again appealed the adverse decision and the claim was forwarded to the Office of Administrative Law Judges ("OALJ") for a hearing. Following a hearing, on September 18, 1995, Administrative Law Judge George A. Fath denied Mr. Holt's claim. While having proved the presence of pneumoconiosis and consequently establishing a material change in conditions, Mr. Holt failed to demonstrate that he was totally disabled from working as a coal miner. Mr. Holt did not appeal the decision (DX 2).

Third, and Present, Claim

On February 13, 2001, Mr. Holt filed a third claim for black lung disability benefits under the Act (DX 3). On July 17, 2002, the District Director denied Mr. Holt's claim. Although Mr. Holt had pneumoconiosis, the medical evidence was insufficient to establish total disability (DX 24) On August 20, 2002, Mr. Holt appealed the denial of his claim (DX 26). The District Director forwarded the claim to OALJ on January 13, 2003 (DX 29). Pursuant to a Notice of Hearing, dated August 26, 2003 (ALJ I), I conducted a hearing in Beckley, West Virginia on December 10, 2003. Mr. Holt and Mr. Frampton attended the hearing.

Evidentiary Discussion[2]

At the hearing, due to my concerns about regulatory evidentiary limitations, I deferred a decision on the admission of two of three CT interpretations contained in EX 2 (TR, pages 16 to

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

[2]In his medical report (DX 22), after referencing Dr. Wheeler's negative interpretation of the November, 11, 2001 chest x-ray, which has been admitted as DX 23, Dr. Zaldivar also reported the positive interpretations of Dr. Scott and Dr. Gayler of the same film. These later two chest x-rays were neither offered nor admitted into evidence. As a result, Dr. Zaldivar's medical opinion contains medical evidence not otherwise admissible under the regulation which represents a technical violation of 20 C.F.R. § 725. 414 (a) (3) (i). Nevertheless, I have not excluded Dr. Zaldivar's medical opinion since his assessment on total disability and discussion about the CT scan findings remain relevant and were not based on his review of the chest x-ray interpretations.

18). Counsel for the Employer asserted all three interpretations were admissible because the regulations did not place a limit on the number of CT scan interpretations that may be admitted into evidence. Additionally, due to the issue concerning the etiology of a radiographic large opacity, good cause existed to allow the admission of all three CT evaluations.[3] Upon review of the new evidentiary restrictions in 20 C.F.R. § 725.414, as asserted by counsel, I find no limit on the number of CT scan interpretations. Accordingly, all three CT scan interpretations are admitted into evidence as EX 2.

During the proceedings, Mr. Holt noted the he had been treated for possible heart problems by Dr. Kohn. I kept the record open for the post-hearing submission of such hospitalization records by the Claimant. I also provided Employer's counsel an opportunity to submit rebuttal evidence to the new admission post-hearing (TR, pages 29 to 31). On December 19, 2003, I received Mr. Holt's medical treatment records from Raleigh General Hospital. To date I have not received any additional medical evidence from Employer's counsel.[4] At this time, I admit into the record Mr. Holt's hospitalization records as CX 1.

In light of the above determinations, my decision in this case is based on the hearing testimony and the following exhibits admitted into evidence: DX 1 to DX 31, CX 1, and EX 1 to EX 4.

ISSUES

1. Responsible Operator

2. Whether, in filing a subsequent claim on February 13, 2001, Mr. Holt has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in September 1995.

3. If Mr. Holt establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated that Mr. Holt had post-1969 coal mine employment (TR, pages 12 and 13).

[3]According to 20 C.F.R. § 725.456 (a), medical evidence in excess of the evidentiary limitation is not admissible "in the absence of good cause."

[4]Since Mr. Frampton mentioned the treatment notes in his closing brief, I am fairly confident that he received a copy of the documents.

Preliminary Findings

Born on March 12, 1936, Mr. Holt started his association with coal at the age of 16 when he hauled coal in a truck for a few years. Around 1954, he started working underground, hand-loading coal. After six years, he transferred to another coal company and ran a buggy for two years before being laid off. In 1966, Mr. Holt started working for Eastern Associated Coal Company ("Eastern") as a buggy and miner operator. About two to three years before the mine shut down in 1989, BenaFuels/Genoa Coal Company became the new operators at the coal mine. Other than a name change and a different name on his pay check, the change in ownership did not alter the mine's operations. When the mine shut down in 1989, Mr. Holt was a miner operator. That job required heavy labor because he had to drag large cables and hoses and hang heavy curtains. After he left mining, Mr. Holt worked as a mechanic and bus driver for a few years. He completely stopped working about six years ago.

Mr. Holt smoked cigarettes for about 15 years and quit in 1982. During that time, he smoked less than a pack of cigarettes a day. Mr. Holt's breathing condition has worsened since his last claim in 1995. He becomes short of breath upon exertion and experienced difficulty on the treadmill test with Dr. Zaldivar. A doctor treats his breathing problems with an inhaler prescription (DX 1 and TR, pages 20 to 28).

Issue #1 – Responsible Operator[5]

Parties' Positions

The Employer objects to its designation as responsible operator in this case for two reasons.[6] First, in the earlier proceedings, Judge Fath dismissed Eastern as the responsible operator. As a result, the Director, OWCP ("Director"), is collaterally estopped from again designating Eastern as the responsible operator in the adjudication of Mr. Holt's subsequent claim.

Second, the substantive record demonstrates that Eastern is not the responsible operator. In particular, as in the prior proceeding before Judge Fath, the Director has failed to establish that the more recent operators to employ Mr. Holt as a coal miner did not have the ability to pay benefits.

In response, counsel for the Director maintains both stated grounds for the requested relief are insufficient.[7] First, a fundamental principle of collateral estoppel is that the earlier

[5]Although 20 C.F.R. § 725.465 (b) removes my authority to dismiss a coal company designated by the Director as the responsible operator, I may nevertheless render a factual determination on whether the designated operator is liable for any benefits payable under the Act.

[6]TR, pages 10 to 12, and November 19, 2004 closing brief.

[7]Although counsel for the Director did not attend the December 2003 hearing, she reserved the opportunity to submit a post-hearing brief on the responsible operator issue (*see* TR, page 11). On December 12, 2003, I issued a

ruling on the issue in dispute in the first proceeding must have been essential for the disposition of that litigation. In Mr. Holt's case, because Judge Fath denied his claim on the merits, the adjudication of the responsible operator issue was not a necessary element to the disposition of the claim. Accordingly, the Director was not collaterally estopped from again naming Eastern as the responsible operator in Mr. Holt's present, subsequent claim.

Second, although two other coal companies, BenaFuels and Genoa Coal Company, were the most recent operators to employ Mr. Holt as a coal miner, neither company is capable of paying any benefits that may be warranted under the Act. Both coal companies were not insured and no longer exist following bankruptcy proceedings. Further, under 20 C.F.R. § 725.495 (c) (2), Eastern bears the burden of demonstrating that the most recent coal company has sufficient assets to secure the payment of benefits under the Act. Eastern presented no such evidence and thus has failed to meet its regulatory burden of production.

Discussion

In terms of collateral estoppel, as correctly stated by the Director's representative, one of four criteria for application of this equitable doctrine is that the determination of the issue must have been necessary to the outcome of the prior proceeding. *See Lane v. Peterson,* 899 F.2d 737 (8th Cir. 1990). In September 1995, Judge Fath denied Mr. Holt's prior claim because he failed to prove that he had developed a totally disabling respiratory impairment. That determination disposed of Mr. Holt's claim. As a result, Judge Fath's additional conclusion that Eastern be dismissed as putative responsible operator was not a necessary determination for the disposition of Mr. Holt's claim. Consequently, in the present claim, Eastern may not invoke the principle of collateral estoppel to preclude its designation as the potential responsible operator.

Turning to the substance of the responsible operator designation, I note that under the provisions of 20 C.F.R. §§ 725.494 and 725.495 the potential responsible operator is defined as the most recent coal mine operator to: a) employ the claimant coal miner for no less than one year; and, b) have the capability of assuming liability for its payment of benefits under the Act through insurance coverage, self-insurance or sufficient assets. In Mr. Holt's case, while BenaFuels and Genoa Coal Company met the first criteria, Eastern has been designated the responsible operator because neither BenaFuels nor Genoa Coal Company satisfy the second criterion.

As required by 20 C.F.R. § 725.495 (d), in January 2002, a representative for the U.S. Department of Labor issued a statement indicating a record search established that neither BenaFuels nor Genoa Coal Company were approved for self-insurance or carried insurance coverage (DX 14). Additionally, the Director noted in his July 17, 2002 Proposed Decision and Order that both BenaFuels and Genoa Coal Company were bankrupt corporations (DX 24). Further, correspondence sent to the president of Genoa Coal Company was returned as undeliverable and a corporate officer for BenaFuels responded that he did not have the financial assets to pay any benefits under the Act (DX 15 and DX 24).

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briefing schedule order providing the parties an opportunity to brief the responsible operator issue. In March 2004, I received the Director's brief.

To avoid liability for the payment of benefits as the designated responsible operator, 20 C.F.R. § 725.495 (c) (2) places the burden on Eastern to prove that BenaFuels or Genoa Coal Company, or the president, secretary, or treasurer of either of these two corporations have "sufficient assets to secure the payment of benefits. . ."[8] Based on the record developed by the Director, a more recent and financially viable entity for the payment of benefits does not appear to exist. Additionally, Eastern has not presented any contrary financial evidence concerning the more recent coal mine operators to support a finding that its designation as the responsible operator in this case is inappropriate. Accordingly, I find that Eastern Associated Coal Company is the responsible operator; correspondingly, its objection to that designation is overruled.

Issue #2 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). The subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (applicable condition of entitlement) has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties 20 C.F.R. § 725.309 (d) (4). Consequently, the first relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by a preponderance of the evidence to receive black lung

[8]In January 2001, a substantial revision to the regulations became effective. As a result, I am guided by significantly different principles on the responsible operator issue than those utilized by Judge Fath. In particular, Judge Fath dismissed Eastern because the Director had not sufficiently established that BenaFuels or Genoa Coal Company lacked the financial ability to meet their respective liabilities under the Act for the payment of benefits. Under the new regulations, 20 C.F.R. § 725.494 places that burden of production on the designated responsible operator to show that a more recent coal mine operator has the financial capacity to meet its benefit obligations under the Act. Due to that regulatory turn of tables, Eastern, and not the Director, bears the consequence of an insufficient record concerning the ability of BenaFuels and Genoa Coal Company to pay black lung disability benefits.

disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[9] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[10] Third, the miner has to demonstrate he is totally disabled.[11] And fourth, the miner must prove the total disability is due to pneumoconiosis.[12]

With those four main conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the only elements that are capable of changing are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Holt's case, his most recent, prior claim was finally denied in September 1995 for failure to prove that he was totally disabled. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since September 1995 to determine whether Mr. Holt can now prove that he has become totally disabled.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

[9] 20 C.F.R. § 718.202.

[10] 20 C.F.R. § 718.203 (a).

[11] 20 C.F.R. § 718.204 (b).

[12] 20 C.F.R. § 718.204 (a).

Mr. Holt has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. Holt must demonstrate total respiratory, or pulmonary, disability through: A – the presence of complicated pneumoconiosis; B – pulmonary function tests; C – arterial blood-gas tests; or, D – medical opinion.

A. Complicated Pneumoconiosis

In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner is suffering from a chronic dust disease of the lung "which then diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C…there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis…"[13] This type of large opacity is called "complicated pneumoconiosis." 20 C.F.R. §§ 718.304 (b) and (c) also permit complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence. The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established.

According to the U.S. Court of Appeals for the Fourth Circuit[14] in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by "congressionally defined criteria." As a result, the statute's definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921 (c) (3) (A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921 (c) (3) (B) and (C). *Id*. at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921 (c) (3) (B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921 (c) (3) (A).[15] Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community's definition of the disease. *Id*. at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated:

[13]On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes of opacities, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B mean an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

[14]Mr. Holt's case arises within the jurisdiction of this court.

[15]See also 20 C.F.R. §§ 718.304 (b) and (c).

> if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id*.

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption of total disability under 20 C.F.R. § 718.304 involves a two-step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence or other diagnostic results exist which are equivalent to chest x-ray evidence of large opacities characterized as Category A, B, or C. At this stage of the process, the essential inquiry is whether such large opacities, or their equivalent, exist. Thus, as observed by the *Scarbro* court, definitive evidence indicating the large opacities are not really present would preclude invocation of the 20 C.F.R. § 718.304 presumption.

Second, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence affirmatively shows the large opacities are not what they seem to be due to some other pathology.

Existence of Large Opacities

Due to the absence of any biopsy reports of massive lesions, Mr. Holt must rely on chest x-ray imaging (20 C.F.R. § 718.304 (a)) or other medical tests (20 C.F.R. § 718.304 (c)), such as CT scans, showing the equivalent of a radiographic image, to establish the presence of large opacities.

Chest X-Rays

Date	**Exhibit**	**Physician**	**Interpretation**
May 1, 2001	DX 11	Dr. Ranavaya, B[16]	Positive for pneumoconiosis, profusion 1/2,[17] type q/r opacities;[18] no large opacities noted. Due to profusion, recommended further study with CT scan.

[16]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[17]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously

(same)	DX 21	Dr. Gayler, BCR, B	Negative for pneumoconiosis; no large opacities noted. Emphysema is present.
May 21, 2001	CX 1	Dr. Daniels	Pneumoconiosis and mild COPD (chronic obstructive pulmonary disease); reticulonodular interstitial fibrosis with developing conglomerate pneumoconiotic densities. "No discrete pulmonary nodule is identified."
November 14, 2001	DX 23	Dr. Wheeler, BCR, B	Negative for pneumoconiosis, profusion 0/1, type q opacities; no large opacities noted. Possible emphysema present. Recommended CT scan to identify localized disease.
December 10, 2001	CX 1	Dr. Reesman	Complicated pneumoconiosis. Coarsened interstitial markings throughout the lungs consistent with coal workers' pneumoconiosis; "conglomerate pneumoconiotic densities."

Of the several physicians to interpret these four recent chest x-rays, only Dr. Reesman indicated the presence of complicated pneumoconiosis in the December 2001 film. However, his finding is outweighed by the consensus of Dr. Ranavaya, Dr. Gayler, Dr. Daniels, and Dr. Wheeler that the other nearly contemporaneous films from 2001 do not disclose the presence of a radiographic image of a large opacity greater than one centimeter. Additionally, Dr. Reesman's finding has diminished probative value because he did not provide sufficient detail to support his conclusion that complicated pneumoconiosis was present. Notably, Dr. Reesman neither described the actual size of the mass that he observed nor characterized the mass as a category A, B, or C opacity.

CT Scan
(EX 2 and EX 4)

Four physicians evaluated an October 2, 2002 CT scan of Mr. Holt's chest. Dr. Paul W. Wheeler identified a 2.5 centimeter "focally calcified granuloma" which he believed was "probably" healed tuberculosis. The imaging also showed a mix of mainly linear and a few small nodules with minimal emphysema. The pattern and shape of the nodules were not consistent with pneumoconiosis.

Dr. John C. Scatarige also noted the presence of a 2.2 centimeter "nodule with calcification" in the left upper lung which he favored attributing to "healed TB (tuberculosis)" Dr. Scatarige also observed the absence of a background of small nodules. As a result, he

considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

[18]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

concluded that pneumoconiosis and silicosis were unlikely. Dr. Scatarige also found moderate emphysema.

Dr. William W. Scott found only linear scarring with a few nodules, most likely due to healed tuberculosis. Minimal emphysema was present.

Dr. Ben V. Branscomb, an emeritus professor in the field of pulmonary medicine, noted numerous small densities. He found one particular "zone" of "congregated . . . little scars." However, according to Dr. Branscomb, "there was no round lesion or no irregular opacity of uniform density that was as large as a centimeter." Additionally, he noted calcification in the densities and little strands radiating from the densities into the pleura which is inconsistent with pneumoconiosis.

The three radiologists and one professor emeritus who evaluated the October 2002 CT scan disagree on whether a large mass is present. Dr. Wheeler and Dr. Scatarige found a 2.5 to 2.2 centimeter mass. Neither Dr. Scott nor Dr. Branscomb found a large nodule. In light of this medical dispute, I find the CT scan evidence is inconclusive in determining whether a large lesion is present in Mr. Holt's lungs.

Had I determined that the CT scan interpretations demonstrated the presence of a large opacity under 20 C.F.R. § 718.304 (c), the courts and Benefit Review Board ("Board")[19] require one additional adjudicatory step at this point prior to a determination that Mr. Holt has established the requisite large opacity. As previously discussed, the statute and regulation legally define complicated pneumoconiosis in terms of a chest x-ray image of a large mass greater than one centimeter. As a result, an additional inquiry must be made whether the CT scan findings by Dr. Wheeler and Dr. Scatarige represent the equivalent of a chest x-ray image of an opacity measuring greater than one centimeter.

While logic and common sense might dictate that a CT scan image of a 2.2 to 2.5 centimeter mass would equate to an x-ray image greater than 1.0 centimeter, the courts have not established a "bright line" demarcation. Instead, the Board requires a specific medical equivalency analysis.[20] However, in Mr. Holt's case, since no physician has rendered an opinion on this issue, no evidentiary basis exists upon which to make the requisite equivalency finding.

To establish complicated pneumoconiosis, Mr. Holt bears the burden of proving that his lungs contain a large opacity, as defined in terms of a chest x-ray image greater than one centimeter. Although two radiologists believe the October 2002 CT scan reveals a 2.2 to 2.5 mass in Mr. Holt's lungs, no evidence exists to demonstrate that this CT scan mass would appear on a chest x-ray as an opacity greater than one centimeter. Accordingly, Mr. Holt is unable to prove the presence of complicated pneumoconiosis under 20 C.F.R. § 718.304 (c).

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[19]*See Double B. Mining, Inc. v. Blankenship,* 177 F3d 240 (4th Cir. 1999) and *Gollie v. Elkay Mining Co.,* 22 B.L.R. 1-306 (2003), *aff'd* 92 Fed. Appx. 52, 2004 WL 759480 (4th Cir. Apr 8, 2004), *cert. denied,* 125 S. Ct. 344 (2004).

[20]*Gollie,* 22 BL.R 1-306 (Board upheld the determination that a physician's opinion that a 2.0 lesion on an autopsy slide would "look like complicated pneumoconiosis" on a chest x-ray did not satisfy the equivalency requirement because the doctor did not specifically state the lesion would be seen as an opacity greater than one centimeter on an x-ray).

Other Medical Evidence

Although I have determined the medical record is insufficient to establish the presence of a large chest x-ray opacity or its equivalent, I also find that even if the October 2002 CT scan had shown a lesion that was the equivalent of a chest x-ray large opacity, other medical evidence demonstrates the lesion is not complicated pneumoconiosis.

In his June 2003 deposition (EX 3), Dr. Zaldivar discussed the interpretations of Mr. Holt's CT scan. Based on these reports, Dr. Zaldivar concluded that in addition to retaining coal dust, Mr. Holt's lungs were scarred by old lung infections. Dr. Zaldivar explained that a CT scan is diagnostically useful due to the section by section images taken during the study. This sectional evaluation will tell a physician whether a chest x-ray image represents a large nodule or superimposed shadows. The CT scan also helps identify whether the image is calcified. In the interpretations of Mr. Holt's CT scan, radiologists identified a large lesion as a calcified granuloma, or a heavy calcium deposit, which is "seen in old scars." This type of lesion is caused by a lung infection, such as tuberculosis, chicken pox, and histoplasmosis or fungal infection. Dr. Zaldivar explained his conclusion as follows:

> Once there is so much calcium in it, one has to think of an infection and not coal workers' pneumoconiosis. Coal workers' pneumoconiosis, complicated, hardly ever becomes calcified like that; there may be some spots of calcium on it, but not heavily calcified . . . coal workers' pneumoconiosis has nothing to do with infection. Infection is produced by an organism.

Dr. Branscomb also discussed the significance of the CT scan study (EX 4). A chest x-ray represents the shadows cast by x-rays as they pass through the lungs. A CT scan is a more sensitive study because the lungs are imaged slice by slice. The CT scan also provides another diagnostic measure because it identifies areas of calcification. This finding is important because, "some other diseases . . .are commonly confused with CWP (coal workers' pneumoconiosis) but differ because they often have calcification, such as tuberculosis and histoplasmosis." Dr. Branscomb noted that once the density has "calcified it's clear, that's not a pattern that is pneumoconiosis." Mr. Holt's densities were granulomas which are "lumpy" scars caused by slow and gradual lung infections. The CT scan also showed linear strands radiating from the densities. Coal worker' pneumoconiosis does not cause that type of strand. Both the calcification and linear strands are consistent with a granulamatous etiology.

In light of their reasoned explanations,[21] I conclude the medical opinions of Dr. Zaldivar and Dr. Branscomb affirmatively establish that the mass isolated in the CT scan is not complicated pneumoconiosis. Thus, due to this affirmative finding, Mr. Holt is unable to invoke

[21]During his examination with Dr. Zaldivar, Mr. Holt reported that he had two tests for tuberculosis that had been negative. Neither Dr. Zaldivar nor Dr. Branscomb mentioned that information in discussing the etiology of the CT scan mass(es). However, their conclusions remain reasoned since the critical defining feature of the CT mass was calcification, which indicated the mass was caused by a lung infection. Notably, in addition to tuberculosis as a possible source of that infection, both physicians mentioned other types of lung infections. In other words, while their assessment does not definitely identify the actual type of lung infection, their explanations reasonably establish that a lung infection and not coal dust caused the mass(es) in Mr. Holt's lungs.

the presumption of total disability due to the presence of complicated pneumoconiosis under 20 C.F.R. § 718.304.

B. Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre[22] post[23]	FVC pre post	MVV pre post	% FEV¹/ FVC pre post	Qualified[24] pre Post	Comments
DX 11	May 1, 2001 Dr. Ranavaya	65 68″	2.46 2.43	4.22 4.12		58.2% 58.9%	No[25]	Minimal airways obstruction
DX 22	Nov. 14, 2001 Dr. Zaldivar	65 68″	2.67 2.85	3.88 3.97	84 75	69% 72%	No No	Mild diffusion impairment

None of the pulmonary function tests reached the total disability thresholds. Therefore, the pulmonary function test evidence does not establish Mr. Holt's total disability according to 20 C.F.R. § 718.204 (b) (2) (i).

C. Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[26]	Comments
DX 11	May 1, 2001 Dr. Ranavaya	39 34.9	90 97.5	No[27] No[28]	
DX 22	Nov. 14, 2001 Dr. Zaldivar	35	88	No	

Since none of the arterial blood gas studies satisfy the regulatory total disability criteria, Mr. Holt cannot establish that he is totally disabled under 20 C.F.R. § 718.204 (b) (2) (ii).

[22]Test result before administration of a bronchodilator.

[23]Test result following administration of a bronchodilator.

[24]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[25]The qualifying FEV1 number is 1.79 for age 65 and 68″; the corresponding qualifying FVC and MVV values are 2.30 and 72, respectively.

[26]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[27]For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[28]For the pCO^2 of 35, the qualifying pO^2 is 65, or less.

D. Medical Opinion

Total disability may also be established under 20 C.F.R. §718.204 (b) (2) (iv) through the preponderance of the more probative medical opinion. Under this regulatory provision, total disability may be found through reasoned medical opinion:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) (1) of this section.

Twenty C.F.R. §718.204(b) (1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. To evaluate total disability under this provision, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). In Mr. Holt's case, based on his description of his work as a miner operator, I find that he engaged in heavy manual labor. With that determination in mind, I turn to the medical opinion in the record.

Dr. Mohammed I. Ranavaya
(DX 11)

On May 1, 2001, Dr. Ranavaya conducted a pulmonary examination. Mr. Holt had over 28 years of coal mine employment. He was a miner operator when he last worked in the coal mines in 1989. Mr. Holt smoked cigarettes from 1952 to 1982 at the rate of about a pack a day. At the examination, Mr. Holt reported chronic shortness of breath upon exertion.

Upon physical examination, Dr. Ranavaya found no pulmonary abnormalities. The blood gas study was normal and the pulmonary function test indicated the presence of a minimal airways obstruction. The chest x-ray was positive for pneumoconiosis. Due to Mr. Holt's length of coal mine employment and the positive radiographic evidence, Dr. Ranavaya diagnosed pneumoconiosis due to coal mine employment. However, Dr. Ranavaya opined the minimal airways obstruction would not preclude Mr. Holt from returning to his last job as a miner operator.

Dr. George L. Zaldivar
(DX 22 and EX 3)

On November 14, 2001, Dr. Zaldivar also evaluated Mr. Holt's pulmonary condition. Mr. Holt reported over 28 years of coal mine employment. When he stopped mining in 1989, he was operating a miner. Mr. Holt started smoking cigarettes when he was 24 years old and stopped in 1981. During this period, he smoked 3/4 of a pack of cigarettes a day. At the time of the examination, Mr. Holt was struggling with chronic shortness of breath and chest pain. He also reported two negative tests for tuberculosis.

Upon physical examination, Mr. Holt's lungs were clear. The radiographic evidence was positive for simple pneumoconiosis. The blood gas study was normal while the pulmonary function test indicated the presence of a mild obstructive impairment. An exercise test was limited due to probable coronary artery disease. Dr. Zaldivar diagnosed simple coal workers' pneumoconiosis and a very mild obstructive impairment which was insufficient to stop Mr. Holt from returning to his coal mine employment. The physician also opined that Mr. Holt's chest pain was possibly related to coronary artery disease.

In a June 17, 2003 deposition, in addition to the CT scan analysis previously summarized, Dr. Zaldivar discussed Mr. Holt's medical record, reviewed the results of his pulmonary evaluation of Mr. Holt, and commented on Dr. Ranavaya's examination. Dr. Zaldivar believed Mr. Holt had simple coal workers' pneumoconiosis. Based on the extent and changing nature of the pulmonary function tests, Dr. Zaldivar opined Mr. Holt had a varying but mild airways impairment which was not disabling. Mr. Holt also had an abnormal EKG; due to premature ventricular contractions, every other heart beat was abnormal. Based on chest x-rays and CT scan interpretations, Dr. Zaldivar concluded Mr. Holt had simple, and not complicated, pneumoconiosis.

Dr. Jebran G. Karam
(CX 1)

At the end of November 2001, Mr. Holt's cardiac condition was evaluated with a cardiac monitor and echocardiogram. The monitor showed Mr. Holt was experiencing thousands of premature ventricular contractions. The echocardiogram showed a small effusion problem that might be related to coronary artery disease.

Due to Mr. Holt's increasing exertional chest pains and the echocardiogram test results, on December 12, 2001, Dr. Karam also performed a cardiac catherization which revealed only minimal irregularities. The left and right coronary arteries were normal.

Dr. Ben V. Branscomb
(EX 1 and EX 4)

In May 2003, Dr. Branscomb conducted a review of the medical records associated with Mr. Holt's claims, including the recent evaluations by Dr. Ranavaya and Dr. Zaldivar. The radiographic and CT scan interpretations were mixed in terms of simple coal workers pneumoconiosis. Based on this evidence, a possibility existed that Mr. Holt had simple coal workers' pneumoconiosis. However, due to the location, shape and distribution of the opacities, Dr. Branscomb did not believe Mr. Holt had pneumoconiosis. Instead, the physician attributed the lesions to "old tuberculosis or other granulomatous pulmonary infection." While at the left apex a "loose coalescence of small opacities" was present; the radiographic evidence did not disclose any nodule greater than one centimeter. Finally, Mr. Holt did not have any "significant pulmonary impairment of any etiology." Mr. Holt's symptoms were best explained by heart disease and de-conditioning.

In a June 18, 2003 deposition, besides discussing the CT scans, Dr. Branscomb again summarized the medical record and repeated his conclusions that Mr. Holt does not have coal workers' pneumoconiosis and is not totally disabled due to a pulmonary impairment.

Discussion

In a manner similar to the pulmonary and arterial tests, none of the physicians who evaluated Mr. Holt's pulmonary capacity to return to coal mine employment considered him totally disabled. Thus, Mr. Holt is unable to prove total disability under 20 C.F.R. §718.204 (b) (2) (iv).

CONCLUSION

Mr. Holt is unable to invoke the presumption of total disability due to the presence of complicated coal workers' pneumoconiosis. Further, none of the newly developed pulmonary function tests, arterial blood gas studies or medical opinion establishes that Mr. Holt has a totally disabling pulmonary impairment. As a result, in his present subsequent claim, Mr. Holt has failed to prove the requisite condition for entitlement under the Act previously adjudicated against him – total disability. Accordingly, under 20 C.F.R. § 725.309 (d) (3), his subsequent claim for black lung disability benefits must be denied.[29]

ORDER

The claim of MR. HOWARD D. HOLT for benefits under the Act is **DENIED**.

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: February 16, 2005
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

[29]Since Mr. Holt failed to establish the requisite change in an element of entitlement, I need not address the third issue, entitlement to black lung disability benefits.